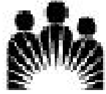

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Electronic Documents Policy

This policy document constitutes the explicit, written permission of Kaiser Foundation Health Plan, Inc., (Health Plan) for the Purchaser to use the accompanying Health Plan Enrollment and Member electronic documents under the following conditions:

These electronic documents must be used as provided, without additions, deletions, or other modifications.

These electronic documents are being provided in English. Translation of these documents by any person/organization other than by Health Plan (or certified translation agencies authorized by Health Plan) is prohibited. Please contact your Health Plan account representative to learn which documents are available in other languages.

These electronic documents may be posted to Purchaser Web sites.

Health Plan will provide updated versions of these electronic documents if there are substantive language changes. Purchasers must transfer the updated versions to their sites as soon as reasonably possible, but not later than 30 days after receipt of an updated document.

The Disclosure Form (DF) is subject to change. Health Plan will provide substantive DF language changes electronically to Purchasers. It is the Purchaser's responsibility to ensure that all changes are provided to employees. All electronic DF documents include a footnote containing an original issuance date to ensure accurate tracking.

If you have questions about our Electronic Documents Policy, or questions about a specific request for an electronic document, please contact your account representative for assistance.

Kaiser Foundation Health Plan, Inc.
California Division

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation and a Medicare+Choice organization

Kaiser Permanente Senior Advantage Evidence of Coverage for LOS ANGELES COMMUNITY COLLEGE DISTRICT

Purchaser ID: 100992 Contract: 4 Version: 33 *EOC* Number: 17

October 1, 2003 through December 31, 2004

Member Service Call Center
7 a.m. to 7 p.m.
Seven days a week (except holidays)
1-800-443-0815
Hearing and speech impaired
TTY line 1-800-777-1370
www.kaiserpermanente.org

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Introduction

About this *Evidence of Coverage (EOC)*

Kaiser Foundation Health Plan, Inc., a federally qualified health maintenance organization (HMO), has a contract with the Centers for Medicare & Medicaid Services (CMS) as a Medicare+Choice organization, which is renewed annually. This contract provides Medicare Services through "Kaiser Permanente Senior Advantage" (Senior Advantage), except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials, which are covered directly by Medicare.

This *Evidence of Coverage (EOC)* describes the Senior Advantage health care coverage provided under the *Agreement* between Kaiser Foundation Health Plan, Inc., and your Group. For benefits provided under any other Health Plan program, refer to that plan's *EOC*. In this *EOC*, Kaiser Foundation Health Plan, Inc., is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC;* please see the "Definitions" section for terms you should know.

Health Plan provides Services directly to our Members through an integrated medical care program, rather than reimbursing expenses on a fee-for-service basis. Please read the following information so that you will know from whom or what group of providers you may obtain health care. It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections applicable to you.

The term of this *EOC* is from October 1, 2003 through December 31, 2004 unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

About Kaiser Permanente Senior Advantage

Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Senior Advantage provides all of the benefits covered by Medicare (except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials, which are covered directly by Medicare) and additional benefits not provided by Medicare.

Kaiser Permanente Senior Advantage provides covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the following sections about:

- Getting a referral, in the "How to Obtain Services" section
- Our Visiting Member Program, in the "How to Obtain Services" section
- Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" section
- Out-of-Area dialysis care, in the "Benefits" section

Through our medical care program, you have convenient access to all of the covered Services you may need, such as routine care with your own Plan Physician, hospital care, laboratory and pharmacy Services, and other benefits described in the "Benefits" section.

Dues, Eligibility, and Enrollment

Dues

Members are entitled to health care coverage only for the period for which we have received the appropriate Dues from your Group. If you are responsible for any contribution to the Dues, your Group will tell you the amount and how you will pay it to your Group. In addition to any amount you must pay your Group, you must also continue to pay your monthly premiums to Medicare.

Note: If you were enrolled in Senior Advantage on December 31, 1998 without Medicare Part A entitlement, you may be eligible to purchase Medicare Part A from Social Security. Please contact the Social Security Administration for more information. If you become entitled to Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group's benefits administrator.

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements in this "Who Is Eligible" section.

Group eligibility requirements

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work to be eligible for coverage. Please note that your Group may not allow enrollment to some persons who meet the requirements under "Additional eligibility requirements."

Medicare eligibility requirements

- You must be entitled to benefits under both Medicare Parts A and B, except for Members enrolled in Senior Advantage on December 31, 1998 without Medicare Part A (Part B only Members), you may continue enrollment without Medicare Part A entitlement
- You may enroll in Senior Advantage regardless of health status, except that you may not enroll if you have end-stage renal disease. This restriction does not apply to you if you are currently a Health Plan Member in the Northern or Southern California Region and you developed end-stage renal disease while a Member
- You may not be enrolled in two Medicare-contracting HMOs at the same time. If you enroll in Senior Advantage, CMS will automatically disenroll you from any other Medicare-contracting plan
- Non-Members may not be able to enroll if Kaiser Permanente Senior Advantage has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply to existing Members who are eligible for Medicare (for example, when you turn age 65)

Service Area eligibility requirements

The Subscriber must live in our Service Area, which is described in the "Definitions" section. However, if you were enrolled in Senior Advantage on December 31, 1998 and lived outside our Service Area, you may continue your membership unless you move and are still outside our Service Area.

Moving Outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months, you cannot continue your Senior Advantage membership under this *EOC*. It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by CMS, you will not be covered by us or Medicare for any care received outside our Plan (except for covered care described in the "Emergency, Urgent, and Routine Care" section about Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers and in the "Benefits" section about Out-of-Area dialysis care). Send your notice to Kaiser Permanente, California Service Center, P.O. Box 232407, San Diego, CA 92193.

If you move to the service area of another Region, you should contact your Group's benefits administrator to learn about your Group health care options. You may be able to continue or transfer your Group membership, if there is an arrangement with your Group that permits membership in the new service area. However, the benefits, copayments, dues, and eligibility requirements may not be the same in the new service area. Also, the benefits, copayments, and service areas where you may apply and enroll can change at any time.

Additional eligibility requirements

You may be eligible to enroll as a Subscriber if you are:

- An employee of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the IRS considers you self-employed)

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

- Your Spouse. For the purposes of this *EOC*, the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 26 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - he or she is under age 19, or under age 26 if a student as defined by your Group
  - he or she receives from you or your Spouse all of their support and maintenance
  - he or she permanently resides with you (the Subscriber)
  - you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Your or your Spouse's Dependents who meet the eligibility requirements stated above, but exceed the age limit for Dependents, may be eligible if the following additional requirements are met:
  - he or she is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit for Dependents
  - he or she receives from you or your Spouse substantially all of their support and maintenance
  - you give us proof of the Dependent's incapacity and dependency within 31 days after we request it

Any of your Dependents who are not entitled to Medicare, as described above, may enroll in another Kaiser Permanente plan offered by your Group. Please contact your Group for details.

Persons terminated for cause or nonpayment

If you have ever had entitlement to receive Services through Health Plan terminated for any of the reasons listed under "Termination for Cause" in the "Termination of Membership" section, you may not enroll until you have completed a Member Orientation and have signed a statement promising future compliance with Health Plan rules. Also, if you have ever had entitlement to receive Services through Health Plan terminated for nonpayment of monthly Dues, you may not enroll until you pay the full amount owed to us.

Enrollment and Effective Date of Coverage

Enrollment

Your Group is required to inform you when you are eligible to enroll and your effective date of coverage. Once your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application and a Senior Advantage Election Form (one form completed and signed by each eligible Medicare beneficiary) to your Group within 30 days.

If you are already a Health Plan Member who lives in the Senior Advantage Service Area, we will mail you information on how to join Senior Advantage and an Election Form shortly before you reach age 65.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment to CMS and send you a notice indicating the effective date of your Senior Advantage coverage. Your effective date will depend on whether you are first becoming entitled to both Medicare Parts A and B, or if you are already entitled to both Medicare Parts A and B.

If you will soon become entitled to both Medicare Parts A and B, your election will be effective on the first day of the month in which you are entitled to both Medicare Parts A and B. If you are already entitled to both Medicare Parts A and B, we will notify you of your effective date. Your effective date will generally be determined by the date we receive your completed Election Form and the effective date of your Group coverage. There are other factors used to determine your effective date, for more information please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Once CMS confirms your enrollment, we will send you written notification. If CMS does not confirm your enrollment in Medicare before your effective date, you still must receive your care from us, beginning on your effective date, just as if your enrollment had been confirmed. If CMS tells us that you are not entitled to both Medicare Parts A and B, we will notify you and request that you contact the Social Security Administration to

clarify your Medicare status. If, after contacting the Social Security Administration, it is confirmed that you are still not entitled to both Medicare Parts A and B, you will be billed for any Services we have provided you unless you are an existing Member under another Kaiser Permanente plan. Members will be responsible for any amounts owed under their other plan and should contact their Group's benefits administrator for details.

Important information about Medicare supplement (Medigap) policies. If you have a Medicare supplement (Medigap) policy, you may consider canceling it after we send you written confirmation of your enrollment in Senior Advantage. However, if you later disenroll from Senior Advantage, you may not be able to have your Medigap policy reinstated.

In certain cases, you can be guaranteed issuance of a Medigap policy without medical underwriting or pre-existing condition exclusions. Examples of these cases include the following:

- You are disenrolled from Senior Advantage because you moved out of our Service Area or for a reason that does not involve any fault on your part (e.g., our contract with CMS terminates)
- You enrolled in Senior Advantage upon first reaching Medicare eligibility at age 65 and you disenroll from Senior Advantage within 12 months of your effective date
- Your supplemental coverage under an employee welfare benefit plan terminates
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no state law provision relating to continuation of coverage
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in Senior Advantage and you disenroll during the first 12 months

You must apply for a Medigap policy within 63 days after your Senior Advantage coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, call the Health Insurance Counseling and Advocacy Program (HICAP) toll free at 1-800-434-0222 (*TTY 1-800-722-3140*).

If you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed by the Medigap policy for Services you receive from us. Most supplemental (Medigap) policies will not pay for any portion of such Services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are a Senior Advantage Member, Original Medicare will not process any claims for Services you receive (except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials)
- Kaiser Permanente has the financial responsibility for all Medicare-covered health Services you need (except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials) as long as you follow Senior Advantage procedures on how to receive Services

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage Election Form (one for each Medicare beneficiary) to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

Notice to New Enrollees about Continuity of Care

If you are currently receiving Services from a non–Plan Provider for an acute medical condition or an acute, serious, or chronic psychiatric condition and your enrollment with us will end coverage of the provider's Services, you may be eligible for temporary coverage of that non–Plan Provider's Services while your care is being transferred to us.

To qualify for this temporary coverage, all of the following criteria must be true:

- Your Health Plan coverage is in effect
- You request this continuing coverage no later than 30 days from the start of your Health Plan coverage by calling our Member Service Call Center toll free at 1-800-443-0815 (TTY 1-800-777-1370), 7 a.m. to 7 p.m., seven days a week

- You are receiving Services during a current episode of care for an acute medical condition or an acute, serious, or chronic psychiatric condition from a non–Plan Provider on the effective date of your Health Plan coverage
- When you chose Health Plan, you were not offered other coverage that included an out-of-network option that would have covered the Services of your current non–Plan Provider
- You did not have the option to continue with your previous health plan or to choose a plan that covers the Services of your current non–Plan Provider
- The non–Plan Provider agrees in writing to our standard contractual terms and conditions, such as conditions pertaining to payment, and providing Services inside our Service Area
- The Services to be provided to you by the non–Plan Provider are Medically Necessary and would be covered Services under the terms of your Health Plan coverage, if provided by a Plan Provider
- Medical Group authorizes the care of your non–Plan Provider because Plan Providers are unable to maintain the continuity of your care

To request this coverage or a copy of our coverage policy, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

How to Obtain Services

Kaiser Permanente Senior Advantage provides covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the following sections about:

- Getting a referral, in this section
- Our Visiting Member Program, in this section
- Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" section
- Out-of-Area dialysis care, in the "Benefits" section

Through our medical care program, you have convenient access to all of the covered Services you may need, such as routine care with your own Plan Physician, hospital care, laboratory and pharmacy Services, and other benefits described in the "Benefits" section.

Your Primary Care Plan Physician

We encourage you to choose a primary care Plan Physician, who will play an important role in coordinating your health care needs, such as hospital stays and referrals to specialists. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. You can also change your primary care Plan Physician for any reason. To learn how to choose or change a primary care Plan Physician, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Special note about Coachella Valley and western Ventura County

To receive care in Coachella Valley and western Ventura County, Subscribers residing in these areas are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In these areas, Plan Providers are referred to as "Affiliated," for example "Affiliated Providers," "Affiliated Physicians," and "Affiliated Specialty Physicians."

Your primary care Affiliated Physician provides or arranges your care in these areas, including Services from other Affiliated Providers, e.g., Affiliated Specialty Physicians. For Services to be covered from other Affiliated Providers, your primary care Affiliated Physician must prescribe the care or authorize the referral, except for annual mammograms and visits to your ob/gyn Affiliated Physician, which may be obtained directly without a referral from your primary care Affiliated Physician.

We will send you a letter explaining how to select a primary care Affiliated Physician. If the Subscriber does not select a primary care Affiliated Physician, we will assign one. Your Dependents may select a different primary care Affiliated Physician than the Subscriber's by calling our Member Service Call Center toll free at 1-800-443-

0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week. You may change your primary care Affiliated Physician once a month.

If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, for assistance. To learn about Affiliated Providers, please refer to *Your Guidebook to Kaiser Permanente Services* or the *Directory of Kaiser Permanente Affiliated Physicians for Coachella Valley and Western Ventura County*. Copies of these directories can be obtained by calling our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Please refer to our Service Area description in the "Definitions" section for the ZIP codes that are in these two areas. You may still receive care from an Affiliated Physician even if you don't live in these areas. If you do live in these areas, you may receive care from Plan Providers in other parts of our Service Area that are not in these two areas.

Getting a referral

Plan Physicians offer primary medical, pediatric, and ob/gyn care as well as specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. However, you can receive care from Plan Physicians in the following specialties without a referral: internal medicine, obstetrics/gynecology, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please refer to your facility's listing in *Your Guidebook* for the departments that do not require a referral.

If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to Medical Group that you be referred to a non–Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will review the request to determine if the Service is Medically Necessary and whether it is available from a Plan Provider. If the Service is Medically Necessary, but not available from a Plan Provider, the request will be approved. Medical Group must authorize the referral in writing in order for us to cover the Services. Copayments for these referral Services are the same as those required for Services provided by a Plan Provider. Please refer to "Second opinions" below for information about obtaining a second opinion from a non–Plan Provider.

Second opinions

If you request a second opinion, it will be provided to you when Medically Necessary by an appropriately qualified health care professional. An appropriately qualified health care professional is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. If you want a second opinion, some examples of when a second opinion is Medically Necessary are:

- If you are unsure about whether a procedure that has been recommended by your Plan Physician is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

To get a second opinion, you can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. If Medical Group determines that there isn't a Plan Provider who is an appropriately qualified health care professional for your condition, Medical Group will authorize a referral to a non–Plan Provider for a Medically Necessary second opinion. Copayments for these referral Services are the same as those required for Services provided by a Plan Provider.

If you have any questions, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Authorization procedure

Certain Services require prior authorization by Medical Group for Services to be covered by us. If Medical Group determines that the Services are Medically Necessary, then Medical Group will authorize them. The Services for which prior authorization is required are the three listed below and referrals to non–Plan Providers, which are described under "Getting a referral" above.

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for the nature of your condition, but no later than five business days after receiving all the information reasonably necessary to make a decision, including information required from you, unless the request is for urgent Services, in which case the decision will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If Medical Group cannot meet these time frames because Medical Group doesn't have information reasonably necessary to make a decision about your request or because Medical Group requested consultation by a particular physician who is an expert in the care you have requested, then Medical Group will inform you and your treating physician, in writing, that they need more time to make this decision. Medical Group will inform you about the additional information they need or the type of expert they need to consult and the date they anticipate that they will make a decision about your request.

Decisions regarding requests for Services will be made only by licensed physicians or other appropriately licensed health care professionals. Any criteria Medical Group uses to make the decision to authorize, modify, delay, or deny your request for Services will be available upon request.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are Medically Necessary, your physician will be informed of the scope of the authorized Services. If Medical Group does not authorize all of the Services, you will receive a written decision that explains the decision within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Dispute Resolution" section.

In addition to referrals to non–Plan Providers described under "Getting a referral" above, these Services require prior authorization by Medical Group:

- **Transplants.** Written referrals from your Plan Physician for transplants will be decided by Medical Group's regional transplant advisory committee or board if one exists. In cases where no transplant committee or board exists, Medical Group will refer you to a transplant center for a determination. The center will approve the transplant if it is Medically Necessary
- **Bariatric Surgery.** If your Plan Physician makes a written referral for bariatric surgery, the referral is reviewed by the Medical Group's regional Bariatric Medical Director or his or her designee, who will determine whether this Service is Medically Necessary in accordance with the bariatric surgery referral guidelines
- **Durable Medical Equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital's DME Coordinator who will verify your DME coverage and determine whether your clinical condition meets the guidelines specified in our DME formulary. If your DME coverage includes the item, but your clinical condition does not appear to meet the guidelines specified by our DME formulary, then the DME Coordinator will contact the Plan Physician for additional information about the request. If the request still does not appear to meet our DME formulary guidelines, the request will be submitted to Medical Group's designee Plan Physician, who will determine whether the item is Medically Necessary

This description is only a brief summary of the authorization procedure. For more information, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week. Please refer to the "Emergency, Urgent, and Routine Care" section for authorization requirements that apply to Post-stabilization Care.

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like more information about the way Plan Physicians are paid to provide or arrange medical and hospital care for Members, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services or Services you obtain from non–Plan Providers.

Termination of a Plan Provider's contract. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Copayments, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Member.

In addition, if you are undergoing treatment for specific conditions from a Plan Physician or certain other providers when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are acute or serious and chronic. We may cover these Services for up to 90 days, or longer if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us. If you would like more information about this provision, or to make a request, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Plan Facilities

At most of our Plan Facilities, you can usually receive all the covered Services you need, including specialized care. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you.

Plan Medical Offices and Plan Hospitals are listed in *Your Guidebook to Kaiser Permanente Services. Your Guidebook* includes information about the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services.

Note: State law requires *Evidence of Coverage* documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, clinic, or call the Kaiser Permanente Member Service Call Center toll free at 1-800-443-0815 to ensure that you can obtain the health care services that you need."

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Our Visiting Member Program

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services as a visiting member from designated providers in that area. Except for covered Emergency Care and Out-of-Area Urgent Care, your right to receive Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

The covered Services and copayments may differ from those under this *EOC* and are governed by our program for visiting members. This program does not cover certain Services, such as transplant or infertility Services. Please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, to receive more information about our visiting member program, including facility locations

in other Regions. The service areas and facilities where you may obtain visiting member Services may change at any time.

Using Your Identification Card

Each Member's Health Plan ID card has a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. Please let us know if we ever inadvertently issue you more than one Medical Record Number by calling our Member Service Call Center. If you need to replace your card, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed for any Services we provide. If you let someone else use your card, we may keep your card and terminate your membership.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, we have a Member Service Call Center staffed with representatives who are available to assist you seven days a week (except holidays), from 7 a.m. to 7 p.m., toll free at 1-800-443-0815 (the toll free TTY line for the hearing and speech impaired is 1-800-777-1370). For your convenience, you can also contact us through our Web site at www.kaiserpermanente.org.

Also, Member Service representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you if you need to file a claim for Emergency Care, Out-of-Area Urgent Care, or Out-of-Area dialysis care received from non–Plan Providers. In addition, they can help you with any issues as described in the "Dispute Resolution" section.

Emergency, Urgent, and Routine Care

This section explains how to obtain covered Emergency Care, urgent care, and routine care. It also describes how our advice nurses can help assess nonemergency medical problems.

The care discussed in this section is not covered unless it meets the coverage requirements stated in the "Benefits" section (subject to the "Exclusions, Limitations, and Reductions" section).

Your Guidebook

Your Guidebook to Kaiser Permanente Services explains how to use our Services and make appointments, and includes a detailed telephone directory for appointments and advice. It also discusses the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. The *Guidebook* is subject to change and periodically updated. We mail *Your Guidebook* annually and you can get a current copy by calling our Member Service Call Center toll free at 1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you have the option of speaking to an advice nurse. They can often resolve a minor concern over the phone or advise you about what to do next, including making a same-day or next-day urgent care appointment for you if it's appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

Routine Care

If you need to make a routine care appointment, please refer to *Your Guidebook* for appointment telephone numbers, or log on to www.kaiserpermanente.org to make an appointment online. Routine appointments are for health care needs that aren't urgent (for example, routine checkups and school physicals). Try to make your routine care appointments as far in advance as possible.

Emergency Care

We cover Emergency Care from Plan Providers and non–Plan Providers anywhere in the world. Emergency Care is Medically Necessary ambulance Services and evaluation by appropriate medical personnel to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility. Please refer to the "Benefits" section for information about ambulance coverage.

An Emergency Medical Condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to your health
- Serious impairment to your bodily functions
- Serious dysfunction of any bodily organ or part

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

If you think you have an Emergency Medical Condition, call 911 or go to the nearest hospital. To better coordinate your Emergency Care, we recommend that you go to a Plan Hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook* for the location of Plan Hospitals that provide Emergency Care.

Special note about Post-stabilization Care

Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care if one of the following is true:

- We provide or authorize the care
- The care was Medically Necessary to maintain stabilization and it was administered within one hour following a request for authorization and we have not yet responded
- The non–Plan Provider and we do not agree about your care and a Plan Physician is not available for consultation
- In the rare circumstance that we are unavailable or cannot be contacted

Covered Post-stabilization Care is effective until one of the following events occurs:

- You are discharged from the non–Plan Hospital
- We assume responsibility for your care
- The non–Plan Provider and we agree to other arrangements

To request authorization for Post-stabilization Care, you must call us before you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non–Plan Provider and decide whether to authorize your care from the non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. Please ask the non–Plan Provider whether we authorized your Post-stabilization Care. However, you will only be held financially liable if you are notified by us or the non–Plan Provider about your potential liability.

Please refer to "Call us for non–Plan admissions or Post-stabilization Care authorization" below for the telephone number to call and additional information about notification requirements.

Urgent Care

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not an Emergency Medical Condition. If you think you may need urgent care, call the appropriate appointment or advice nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

If you are temporarily outside our Service Area and have an urgent care need due to an unforeseen illness or injury, we cover the Medically Necessary Services you receive from a non–Plan Provider if we find that the Services were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to our Service Area.

Also, in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as, major disaster, epidemic, war, riot, and civil insurrection), we cover urgent care inside our Service Area from a non–Plan Provider.

Additional Coverage Limitations

Call us for non–Plan admissions or Post-stabilization Care authorization

You must call us at 1-800-225-8883 (this telephone number is also on your ID card) to:

- Request authorization for Post-stabilization Care *before* you obtain the care from a non–Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible)
- Notify us that you have been admitted to a non–Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate with the treating physician's concurrence. If you don't notify us as soon as reasonably possible, we may not cover any Services you receive after transfer would have been possible

We know that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. If you don't call us when it becomes possible for you to call, you may be financially responsible for the cost of the unauthorized Services received after you became Clinically Stable.

Reimbursement for non–Plan Emergency and Out-of-Area Urgent Care received from non–Plan Providers

We do not cover continuing or follow-up treatment provided by non-Plan Providers unless it is covered care described under Emergency Care, Post-stabilization Care, or Out-of-area Urgent Care above. Our reimbursement will be reduced by applicable Copayments (which are the same Copayments required for Services provided by a Plan Provider) and by all amounts paid or payable under any other coverage, or those that would be payable in the absence of this plan, if by law Medicare is a secondary payer.

The procedure for obtaining reimbursement for Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers is described under "Non-Plan Emergency Care or Out-of-Area Urgent Care and Out-of-Area Dialysis Care" in the "Requests for Payment or Services" section.

Benefits

The Services described in this "Benefits" section are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the following sections about:
  - our visiting member program, in the "How to Obtain Services" section
  - Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the following sections about:
  - getting a referral, in the "How to Obtain Services" section
  - our visiting member program, in the "How to Obtain Services" section
  - Emergency Care and Out-of-Area Urgent Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" section
  - out-of-area dialysis care, in this section

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, and Reductions" section. Also, please refer to:

- The “Emergency, Urgent, and Routine Care” section for information about how to obtain Emergency Care, urgent care, and routine care
- The "Copayments" section for the Copayments you must pay for covered Services described in this section
- *Your Guidebook to Kaiser Permanente Services* for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Special Note about Services Associated with Clinical Trials

Original Medicare will pay for certain Services related to qualifying clinical trials. This is not covered by us. You should continue to come to Plan Providers for all covered Services that are not part of the clinical trial. Medicare will pay for many, but not all, Services associated with qualifying clinical trials. You should ask the clinical trial provider if the clinical trial qualifies for Medicare payments and what Medicare coinsurance and other out-of-pocket expenses you will have to pay for related Services. Original Medicare does not require that you get a referral from a Plan Physician to join a qualifying clinical trial. However, you should tell us before you join a clinical trial outside of Kaiser Permanente so we can keep track of your Services. For more information on Medicare payments for clinical trials and which trials qualify, please call Medicare directly at 1-800-MEDICARE (1-800-633-4227) (*TTY 1-877-486-2048*).

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment:

- Primary care visits for internal medicine, gynecology (including cervical cancer screening tests and mammograms), family practice, and pediatrics
- After confirmation of pregnancy, all Obstetrical Department prenatal visits and the first postpartum visit
- Physical examinations and preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines when prescribed by a Plan Physician: X-rays, sigmoidoscopy, and stool tests. For Members age 50 and over, who are not at high risk of developing colon cancer, Medicare covers colonoscopy every 10 years or no sooner than four years after a sigmoidoscopy. You should consult with your Plan Physician to determine what is appropriate for you
- Specialty care visits, including consultation and second opinions with Plan Physicians in departments other than those listed under "Primary care visits" above
- Outpatient surgery
- Respiratory therapy
- Blood, blood products, and their administration
- Medical social services

- House calls inside our Service Area when care can best be provided in your home as determined by a Plan Physician
- Manual manipulation of the spine to correct subluxation, as covered by Medicare, is provided by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans). A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, please refer to your ASH Plans provider directory. To request an ASH Plans provider directory, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week
- Emergency Department visits (please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care)

The following types of outpatient Services are covered only as described under these headings in this "Benefits" section:

- Chemical Dependency Services
- Dialysis Care
- Drugs, Supplies, and Supplements
- Durable Medical Equipment
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Imaging, Laboratory, and Special Procedures
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists
- Anesthesia
- Medical supplies
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge
- Respiratory therapy
- Medical social services and discharge planning

The following types of inpatient Services are covered only as described under the following headings in this "Benefits" section:

- Chemical Dependency Services
- Dialysis Care
- Drugs, Supplies, and Supplements
- Durable Medical Equipment

- Hospice Care
- Imaging, Laboratory, and Special Procedures
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Religious Nonmedical Health Care Institution Services
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

We cover emergency Services of a licensed ambulance. We cover emergency ambulance Services that are not ordered by us if all of the following are true:

- You are experiencing acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health, serious impairment to your bodily functions, or serious dysfunction of any bodily organ or part
- You reasonably believe that your condition requires ambulance transportation

We also cover nonemergency ambulance Services for transportation if your condition meets Medicare guidelines.

Ambulance Services exclusion

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider, is not covered

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including dependency recovery Services, education, and counseling.

Outpatient

We cover the following Services for treatment of chemical dependency:

- Day treatment programs
- Intensive outpatient programs
- Counseling (both individual and group visits) for chemical dependency
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by Medical Group. We do not cover methadone maintenance treatment in any other circumstances

Transitional residential recovery Services

We cover up to 60 days per calendar year of care in a nonmedical transitional residential recovery setting approved in writing by Medical Group; no more than 120 days of covered care is provided in any five consecutive calendar year period. These settings provide counseling and support services in a structured environment.

Chemical dependency Services exclusions

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as described above

Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following conditions are met:

- You satisfy all the medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment

We also cover peritoneal home dialysis (including equipment, training, and medical supplies).

Out-of-Area dialysis care

We cover dialysis for end-stage renal disease at a Medicare-certified facility that is needed while you are traveling temporarily outside our Service Area. There is no limit to the number of covered routine dialysis days. Although it is not required, we ask that you contact us before you leave our Service Area so we can coordinate your care when you are temporarily outside our Service Area. Please refer to your ESRD patient material for more information.

Note: The procedure for obtaining reimbursement for Out-of-Area dialysis care is described in the "Requests for Payment or Services" section.

Drugs, Supplies, and Supplements

We cover drugs, supplies, and supplements specified below and drugs covered by Medicare when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines. Also, you must obtain covered drugs, supplies, and supplements from a Plan Pharmacy or another pharmacy that we designate. It may be possible for you to receive refills by mail; ask for details at our pharmacy.

Please be aware that durable medical equipment used to administer drugs is not covered under this section (instead, refer to the "Durable Medical Equipment" section).

Administered drugs, supplies, and supplements

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

- Drugs, injectables, internally implanted time-release contraceptives, intrauterine devices (IUDs), radioactive materials used for therapeutic purposes, vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), and allergy test and treatment materials

Self-administered IV drugs, supplies, and supplements

We cover certain drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an IV or intraspinal-infusion). We also cover the supplies and equipment required for their administration. Injectable drugs, insulin, and drugs for the treatment of infertility are not covered under this paragraph.

Diabetes urine-testing supplies and insulin-administration devices

We cover the following diabetes urine-testing supplies: ketone test strips and sugar or acetone test tablets or tapes. Note: Diabetes blood-testing equipment and their supplies are not covered under this section (refer to the "Durable Medical Equipment" section).

We cover the following insulin-administration devices: disposable needles and syringes, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear). Note: Insulin pumps and their supplies are not covered under this section (refer to the "Durable Medical Equipment" section).

Outpatient drugs, supplies, and supplements

We cover the following drugs, supplies, and supplements when prescribed by a Plan Physician or dentist (drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary):

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. Note: Smoking-cessation drugs are covered if you participate in a Plan-approved behavioral intervention program
- Diaphragms, cervical caps, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs

Special note about our drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like information about whether a particular drug is included in our drug formulary, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance or an appeal as described in the "Dispute Resolution" section. Also, our formulary guidelines may require you to participate in a Plan-approved behavioral intervention program for specific conditions and you may be required to pay for the program.

Drugs, supplies, and supplements exclusions

Any drugs, supplies, and supplements needed in connection with a Service that is not covered under this *EOC* unless they are required to treat a complication that arises after a noncovered Service

- Any requested packaging (such as dose packaging), other than the dispensing pharmacy's standard packaging
- Compounded products unless the product is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs to shorten the duration of the common cold

Note: If a drug for which a prescription is required by law is no longer covered, and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50 percent of Charges if a Plan Physician continues to prescribe the drug for the same condition (please refer to the "Definitions" section for the meaning of "Charges").

Durable Medical Equipment

Inside our Service Area, we cover durable medical equipment (DME) in accord with our DME formulary and Medicare guidelines. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

We cover durable medical equipment as prescribed by a Plan Physician for use in your home (or an institution used as your home). We also cover equipment, including oxygen-dispensing equipment and oxygen used during a covered stay in a Plan Hospital or Skilled Nursing Facility, if a Skilled Nursing Facility ordinarily furnishes the equipment.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to misuse.

Note: Diabetes urine-testing supplies and other insulin-administration devices are not covered under this section (refer to "Drugs, Supplies, and Supplements").

Durable medical equipment exclusions

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Dental appliances
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies, such as blood glucose monitor test strips and lancets)
- Electronic monitors of the heart or lungs except infant apnea monitors

Family Planning Services

We cover the following:

- Family planning counseling, including preabortion and postabortion counseling and information on birth control
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy

Note: Diagnostic procedures are not covered under this section (see "Imaging, Laboratory, and Special Procedures"). Also, contraceptive drugs and devices are not covered under this section (see "Drugs, Supplies, and Supplements").

Health Education

We cover a variety of health education programs to help you protect and improve your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). You can also participate in programs and classes that we don't cover, which may require that you pay a fee. For more information about our health education programs, please contact your local Health Education Department or call our Member Service Call Center 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, or log on to www.kaiserpermanente.org. *Your Guidebook to Kaiser Permanente Services* also includes information about our health education programs.

Note: In accord with Medicare guidelines any diabetes self-management training courses, accredited by the American Diabetes Association may be available to you if you receive a referral from a Plan Physician.

Hearing Services

We cover the following:

- Hearing tests to determine the need for hearing correction
- Hearing tests to determine the appropriate hearing aid
- An allowance for each ear toward the price of a hearing aid every 36 months when prescribed by a Plan Physician or Plan audiologist. The allowance amount is listed in the "Copayments" section. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the allowance if we have covered a hearing aid for that ear within the previous 36 months. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later
- Visits to verify that the hearing aid conforms to the prescription
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted

We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

We cover home health Services only inside our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Home health Services are Medically Necessary health Services prescribed by a Plan Physician that can be safely and effectively provided in your home by health care personnel and are directed by our Home Health Committee, which is comprised of Plan Physicians and other health care professionals.

Home health Services are limited to Medicare-covered home health Services, such as part-time or intermittent skilled nursing care, part-time or intermittent service of a home health aide, medical social services, and medical supplies. The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- Drugs, Supplies, and Supplements
- Durable Medical Equipment
- Ostomy and Urological Supplies
- Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services
- Prosthetic and Orthotic Devices

Home health care exclusions

- Home health Services do not include custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section) and homemaker Services
- Care that the Home Health Committee determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility and we provide, or offer to provide, that care in one of these facilities

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the Services listed below only if all of the following requirements are met:

- You are not entitled to Medicare Part A
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area by a licensed hospice agency approved by Medical Group
- The Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, which are available on a 24-hour basis to the extent necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers

- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies or other pharmacies that we designate. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms: nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home and short-term inpatient care required at a level that cannot be provided at home

Special note for Members with Medicare Parts A and B

Medicare covers hospice care directly for Members with Medicare Parts A and B; we do not cover the care. Although we do not cover it, if your Plan Physician determines you are eligible for and you wish to elect hospice care, we will assist you in identifying Medicare-certified hospices, including any Kaiser Permanente hospice, in your area. The hospice will bill Medicare directly for the care ordered by the hospice team. In addition, the hospice may charge you 5 percent of the reasonable cost of outpatient drugs or biologicals for pain relief and symptom management (up to a maximum of $5 for each prescription). The hospice may also charge you approximately $5 for each day of inpatient respite care. Note: If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this *EOC* or Medicare. However, we will continue to cover the Services described in this *EOC* that are not related to the terminal illness. You may change your decision to receive hospice care at any time.

Imaging, Laboratory, and Special Procedures

We cover the following Services only when prescribed as part of care covered under other parts of this "Benefits" section (for example, diagnostic imaging and laboratory tests are covered for infertility only to the extent that infertility Services are covered under "Infertility Services"):

- Diagnostic and therapeutic imaging
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available
- Special procedures, such as electrocardiograms and electroencephalograms
- Ultraviolet light treatments
- Annual mammograms for women age 40 and over (no referral required)

Infertility Services

We cover the following Services:

- Services for diagnosis and treatment of involuntary infertility
- Artificial insemination (except for donor semen or eggs, and Services related to their procurement and storage)

Note: Diagnostic procedures are not covered under this section (refer to "Imaging, Laboratory, and Special Procedures"). Also, drugs, supplies, and supplements are not covered under this section (refer to "Drugs, Supplies, and Supplements").

Infertility Services exclusion

- Services to reverse voluntary, surgically induced infertility

Mental Health Services

We cover mental health Services as specified below, except that any inpatient-day limits specified below do not apply to the following conditions:

- Serious emotional disturbances of a child as defined in Section 1374.72(e) of the California Health and Safety Code
- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa

For all other mental health conditions, we cover mental health Services in accord with Medicare guidelines and coverage is limited to treatment for psychiatric conditions that are amenable to active treatment, and for which active treatment provides a reasonable prospect of improvement or maintenance at a functional level.

Outpatient mental health Services

We cover:

- Individual and group therapy visits for diagnostic evaluation and psychiatric treatment
- Psychological testing
- Visits for the purpose of monitoring drug therapy

Inpatient psychiatric care

We cover up to 190 days per lifetime for acute psychiatric conditions in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. After you exhaust these lifetime days, we cover up to 45 days per calendar year.

Hospital alternative Services

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care. Hospital alternative Services include partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.

Note: Drugs, supplies, and supplements are not covered under this section (refer to "Drugs, Supplies, and Supplements").

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our durable medical equipment formulary and Medicare guidelines, during a covered stay in a Plan Hospital and Skilled Nursing Facility, or in Plan Medical Offices and Plan Hospital Emergency Departments, or for home use. We select the vendor and coverage is limited to the standard item of equipment that adequately meets your medical needs.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

Physical, occupational, and speech therapy

In accord with Medicare guidelines, we cover initial and subsequent courses of physical, occupational, and speech therapy in a Plan Facility or Skilled Nursing Facility, or as part of home health care, if in the judgment of a Plan Physician:

- Significant improvement is expected within a reasonable and generally predictable period, or
- The therapy is necessary to establish a maintenance program required in connection with certain medical conditions

Limitations

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living

Multidisciplinary rehabilitation Services

If, in the judgment of a Plan Physician, continuing significant improvement in function is achievable within a reasonable and generally predictable period, we will cover treatment in accord with Medicare guidelines in an organized, multidisciplinary rehabilitation program in a Plan Facility or Skilled Nursing Facility.

Prosthetic and Orthotic Devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, devices are limited to the standard device that adequately meets your medical needs. We also cover enteral formula for Members who require tube feeding in accord with Medicare guidelines.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we do not cover the device, we try to help you find facilities where you may obtain what you need at a reasonable price.

Internally implanted devices

We cover internal devices implanted during covered surgery, such as pacemakers and hip joints, that are approved by the federal Food and Drug Administration for general use and are covered by Medicare.

External devices

We cover the following external prosthetics and orthotics:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx including electronic voice-producing machines covered by Medicare
- Prostheses needed after a covered mastectomy, including custom-made prostheses when Medically Necessary
- Prosthetics and orthotics that are covered by Medicare, including therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist
- Compression burn garments and lymphedema wraps and garments

Prosthetic and orthotic devices exclusions

- Eyeglasses and contact lenses under this benefit (see "Vision Services" section)
- Hearing aids under this benefit (see "Hearing Services" section)
- Dental appliances
- Except as described above, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Electronic voice-producing machines except as covered by Medicare
- Shoes or arch supports, even if custom-made, unless indicated above

Reconstructive Surgery

We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.

Mastectomies

Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance
- Prosthetic and orthotic devices are covered only as described under "Prosthetic and Orthotic Devices"

Religious Nonmedical Health Care Institution Services

Certain Services in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) are covered. However, religious aspects of care provided in a RNHCI are not covered. If you want to receive care in a RNHCI, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, to learn about the requirements you must satisfy.

Skilled Nursing Facility Care

Inside our Service Area, we cover up to 100 days per "benefit period" of skilled inpatient Services in a licensed Skilled Nursing Facility when prescribed by a Plan Physician and in accord with Medicare guidelines. The skilled inpatient Services must be Medically Necessary, customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care. A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines). A benefit period ends on the date you have not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Medical social services
- Drugs covered under "Drugs, Supplies, and Supplements"
- Blood, blood products, and their administration
- Equipment described under "Durable Medical Equipment"
- Medical supplies
- Procedures covered under "Imaging, Laboratory, and Special Procedures"
- Services covered under "Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services"
- Respiratory therapy

Home Skilled Nursing Facility

Upon discharge from a Plan Hospital, we will provide Skilled Nursing Facility coverage at the following Skilled Nursing Facilities inside our Service Area, if we have an agreement with the Skilled Nursing Facility to provide you the care described above:

- The Skilled Nursing Facility where you were residing at the time of your hospital admission
- A Skilled Nursing Facility that provides post-hospital skilled nursing Services through a continued care retirement community where you were residing at the time of your hospital admission
- The Skilled Nursing Facility where your Spouse is residing at the time you are discharged from the hospital

Note: If you choose to go to a home Skilled Nursing Facility that is not one of our approved facilities, we make no representations about, and assume no liability for, the quality of care provided to you at that facility.

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if Medical Group provides a written referral for care to a transplant facility as described under “Getting a referral” and "Authorization procedure," in the “How to Obtain Services” section.

After the referral to a transplant facility, the following applies:

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our criteria for donor Services, we provide certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services is available by calling our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week

Transplant Services exclusions

- Services related to nonhuman or artificial organs and their implantation

Vision Services

We cover the Services listed below at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or Plan optometrist.

Eye exams

Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses. We also cover glaucoma screenings in accord with Medicare guidelines.

Optical Services

Eyeglasses and contact lenses. We provide an allowance toward the price of eyeglass lenses, frames, and contact lenses, fitting, and dispensing every 24 months when prescribed by a Plan Physician or Plan optometrist. You will find the allowance amount in the "Copayments" section. We will not provide the allowance if we have covered lenses or frames within the previous 24 months. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later.

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of initial point of sale, we will provide an allowance toward the price of a replacement eyeglass lens (or contact lens, fitting, and dispensing). The allowance for these replacement lenses is $60 for single-vision eyeglass lenses or contact lenses, fitting, and dispensing and $90 for multifocal eyeglass lenses.

Special contact lenses. We cover the following special contact lenses when prescribed by a Plan Physician or Plan optometrist:

- We will provide up to two contact lenses per eye every 12 months to treat aniridia (missing iris)
- We will provide up to five aphakic contact replacement lenses per eye under this or any other *EOC* for children from birth through age 9 (aphakia is the absence of the crystalline lens of the eye)
- If contact lenses will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses or an initial supply of disposable contact lenses every 24 months. When we cover these special contact lenses, you cannot use the allowance described in "Eyeglasses and contact lenses" for another 24 months. However, if the combination of special contact lenses and eyeglasses will provide a significant improvement in your vision not obtainable with special contact lenses alone, you can use that allowance toward the purchase of the eyeglasses if we have not covered lenses or frames within the previous 24 months. If you have a change in prescription of at least .50 diopter in one or both eyes, we will cover special contact lens replacements, including fitting and dispensing

Eyeglasses and contact lenses following cataract surgery. In accord with Medicare guidelines, we provide a $150 allowance for each affected eye to pay for eyeglass lenses, frames, and contact lenses, fitting, and dispensing. The allowance applies to each affected eye following cataract surgery and is provided once per lifetime. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance for one eye at the initial point of sale, you cannot use it later.

Vision Services exclusions

- All Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Industrial frames
- Lenses and sunglasses without refractive value except for:
  - A balance lens if only one eye needs correction
  - Medically Necessary lenses to treat macular degeneration or retinitis pigmentosa
- Replacement of lost, broken, or damaged lenses or frames
- Lens adornment, such as engraving, faceting, or jeweling
- Low-vision devices
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits

Exclusions, Limitations, and Reductions

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC*. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this *EOC.*

Certain exams and Services

Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance or licensing, or (c) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor. Manual manipulation of the spine as covered by Medicare is provided as described under "Outpatient Care" in the "Benefits" section.

Conception by artificial means

All Services (other than artificial insemination described under "Infertility Services" in the "Benefits" section) related to conception by artificial means, such as but not limited to: ovum transplants, gamete intrafallopian transfer (GIFT), donor semen or eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Cosmetic Services

Plastic surgery or other cosmetic Services that are intended primarily to improve your appearance, except for Services covered under "Reconstructive Surgery" in the "Benefits" section.

Custodial care

Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

This exclusion does not apply to Services covered under "Hospice Care" in the "Benefits" section.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment. This exclusion does not apply to Medically Necessary care covered by Medicare or evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers you to a dentist (as described under "Getting a referral") to prepare your jaw for radiation treatment of cancer.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with Medical Group, determine that:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients), or
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Hospice Care" in the "Benefits" section.

Routine foot care Services

Routine foot care, except for Medically Necessary Services covered by Medicare.

Services not available in our Service Area

Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

Sexual reassignment surgery

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" in the "Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.

Travel and lodging expenses

Travel and lodging expenses for any person, including a Member. However, in some situations, if Medical Group refers you to a non–Plan Provider as described under "Getting a referral," we may preauthorize certain expenses in accord with our travel and lodging policy and so notify you.

Limitations

We will use our best efforts to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone routine or elective care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences in the judgment of a Plan Physician.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and if we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and if we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

You must pay us Charges for covered Services you receive for an injury or illness that is alleged to be caused by a third party's act or omission, except that you do not have to pay us more than you receive from or on behalf of the third party.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the recovery is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Kaiser Permanente
Special Recovery Unit-8553
Parsons East, 2nd Floor
P.O. Box 7017
Pasadena, CA 91109-9977

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You must not take any action prejudicial to our rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Medicare law may apply with respect to Services covered by Medicare.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Medicare as secondary payer

Auto and liability insurance. When Medicare by law is the secondary payer, federal law authorizes health plans to seek reimbursement from the medical expense provisions of any motor vehicle insurance covering you, and any liability insurance that provides payment for injuries or illness to you. We will reduce your benefits under this *EOC* by all amounts paid or payable under your other health plan or insurance policy. You must complete and submit to us all consents, releases, assignments, and other documents necessary for us to obtain or assure such payment. If you fail to do so, then we may, at our discretion, require you to pay for the Services.

Coordination of benefits (COB). In certain cases, this *EOC* is subject to coordination of benefits. COB applies when you have health benefits coverage through more than one health care plan and one of them is Group coverage that is subject to Medicare secondary payer law. If federal law requires that a Group's coverage be primary and Medicare coverage be secondary, we or the other health care plan will coordinate benefits with the plan whose Group coverage is primary by law. We will ask if you have other coverage. If you have other health care plan coverage, you must help us obtain payment from them by providing the information we request. The following are situations when Medicare is secondary for the purposes of COB:

- If you are age 65 or older and have group health care coverage through an employer with 20 or more employees, either through your or your Spouse's current employment (this applies to most employers with 20 or more employees)
- If you are under age 65 and entitled to Medicare due to disability and have coverage under a large employer group health plan (100 or more employees), either through your own employment or the employment of a family member
- If you become eligible for, or entitled to, Medicare based on end-stage renal disease (ESRD) and are covered by an employer group health plan, you will be subject to a 30-month benefit coordination period, during which time Medicare is secondary payer, if: (1) ESRD is the sole basis for your Medicare eligibility or entitlement, (2) you also become eligible for or entitled to Medicare based on age or disability during the first 30 months of your ESRD-based eligibility or entitlement, or (3) you are entitled to Medicare based on age or disability and are subject to Medicare secondary payer provisions (refer to the first two bullets above)

Medicare benefits

As a Senior Advantage Member, you receive all Medicare covered benefits through us (except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials, which are covered directly by Medicare) and these benefits are not duplicated.

Surrogacy arrangements

You must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

Kaiser Permanente
Special Recovery Unit
Parsons East, 2nd Floor
P.O. Box 7017
Pasadena, CA 91109-9977
Attention: Third Party Liability Supervisor

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You must not take any action prejudicial to our rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Veterans Administration

For any Services for conditions arising from military service that the law requires the Veterans Administration to provide, we will not pay the Veterans Administration, and if we cover any such Services we may recover the value of the Services from the Veterans Administration.

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any such Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Requests for Payment or Services

Requests for Payment

Non-Plan Emergency Care or Out-of-Area Urgent Care and Out-of-Area Dialysis Care

If you receive Emergency Care, Out-of-Area Urgent Care, and Out-of-Area dialysis care from a non–Plan Provider (as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care and Out-of-Area Urgent Care and in the "Benefits" section about Out-of-Area dialysis care), ask the non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses and bills you, send us the unpaid bill with a claim form. To file a claim, this is what you need to do:

- As soon as possible, get our claim form by calling our Member Service Call Center toll free at 1-800-443-0815 or 1-888-634-1300 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week. Also, one of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills from the non–Plan Provider and receipts
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:

  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 7102
  Pasadena, CA 91109-9880

We will notify you of our decision within 60 days after we receive your claim. If we totally or partially deny your claim, we will notify you in writing of the reasons for denial and of your right to seek reconsideration. If you have not received a determination on your claim within 60 days after we receive your claim, you may assume the determination is negative and you may use the Medicare appeals procedure described in the "Dispute Resolution" section.

Other Services

To request payment for Services (except for Emergency Care or Out-of-Area Urgent Care and Out-of-Area dialysis care from non–Plan Providers) that you believe should be covered, you or your non–Plan Provider must submit a written request to your local Member Services Department. Please attach any bills and receipts if you

have paid any bills. Please be aware that we may not pay for Services provided by non-Plan Providers who have been sanctioned or debarred by Medicare, or who have opted out of Medicare.

We will respond to your claim within 60 days. If we deny your claim, we will tell you the specific reasons for the denial. If you have not received a notice about our determination on your claim within 60 days after we receive it, you may assume the decision is negative and you may request an appeal. Likewise, if you disagree with our decision, you may appeal our decision as described in the "Dispute Resolution" section.

Requests for Services that you have not yet received

Standard decision

You may request that we provide Services that you have not yet received (except for hospice care for Members with Medicare Parts A and B), but that you believe you are entitled to receive through Kaiser Permanente. These requests should be submitted in writing to your local Member Services Department. We will respond to your request within 14 days. If we deny your request, we will send you a notice that explains the reason for the denial and provides information about your appeal rights as described in the "Dispute Resolution" section.

Expedited decision

You may ask that we make an expedited decision on your request. Expedited requests may be made orally or in writing. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 14 days for a standard decision. We may extend our decision for up to 14 days if it is in your interest, or if you request an extension. For example, our decision may take longer if we have to wait for medical information from a non–Plan Provider.

You or your physician may request an expedited decision by calling toll free 1-888-987-7247 or by sending your written request to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Medicare Expedited Review. You may also fax your request to 1-888-987-2252, or deliver your request in person to your local Member Services Department. Specifically state that you want an expedited decision, 72-hour decision, or that you believe that your health could be seriously harmed by waiting 14 days for a decision. If we deny your request for an expedited decision, we will give you prompt oral notice and provide written notice within 72 hours. The notice will include information about your grievance rights as described in the "Dispute Resolution" section. Also, we will automatically transfer your request for a standard decision review and make a decision within 14 days from the date of the request.

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns if an issue arises. Our Member Service representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*) 7 a.m. to 7 p.m., seven days a week. The following procedures for resolving disputes are discussed in detail below:

- **Standard Medicare appeal procedure.** To appeal denied claims for payment or denied requests for Services when an expedited Medicare appeal is not required. Does not apply to hospice care for Members with Medicare Parts A and B.
- **Expedited Medicare appeal procedure.** To appeal discontinuation of Services, or denied requests for Services when your health or ability to function could be seriously harmed by waiting 30 days for a standard Medicare appeal. Does not apply to hospice care for Members with Medicare Parts A and B.
- **Immediate Quality Improvement Organization (QIO) review.** To appeal denial of continued coverage of a stay in a hospital when we have determined that hospitalization is no longer Medically Necessary.
- **Grievance procedure.** To report any quality of care concerns you have and to seek resolution of an issue that is not subject to a Medicare appeals procedure.
- **Quality Improvement Organization complaint procedure.** To report concerns about the quality of care you receive, you can also file a complaint with your local Quality Improvement Organization.
- **Binding arbitration.** To resolve all other claims arising from your membership, unless otherwise indicated below.

Special note about hospice care

For Members entitled to Medicare Parts A and B, Medicare covers hospice care directly and it is not covered under this *EOC*. Therefore, any disputes related to the coverage of hospice care for Members entitled to Medicare Parts A and B must be resolved directly with Medicare and not through any dispute resolution procedure discussed in this section.

Standard Medicare Appeal Procedure

This procedure applies to denied requests for Services and denied claims for payment of Services received from non–Plan Providers, including those related to Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and Out-of-Area dialysis care (it does not apply to hospice care). For claims, we will process your reconsideration request within 60 days. For denied requests for Services that you believe are covered under this *EOC*, we will process your reconsideration request within 30 days from receipt of the reconsideration request. If it is in your best interest, or if you request, we may extend our decision for an additional 14 days beyond the 30-day period. If we must extend the time frame, we will provide written notice and information about your grievance rights. **We will use this procedure to reconsider all claims and requests unless the expedited (72-hour) Medicare appeal procedure applies.**

If we deny your initial claim for payment or request for Services, we will tell you the specific reasons for the denial in a written denial notice. If you disagree with our decision, you have the right to request a reconsideration of our decision. Your reconsideration request must be filed in writing with us at the address shown on your denial notice, or with an office of the Social Security Administration, or if you are a qualified Railroad Annuitant, with the Railroad Retirement Board office. Even though you may file your reconsideration request with the office of the Social Security Administration or with the Railroad Retirement Board office, that office will transfer your reconsideration request to us for processing.

You must submit your reconsideration request within 60 days from the date on the denial notice, unless you show good cause for a delay past 60 days. You have the right to submit any new information to support your reconsideration request in person or in writing.

If we do not rule fully in your favor, we will forward your reconsideration request to the CMS contractor, The Center for Health Dispute Resolution (The Center), for a decision. The Center will then make its own reconsideration decision and advise you of its decision, the reason for its decision, and your rights to a hearing before an administrative law judge.

If our standard reconsideration decision is fully in your favor for the Services you requested, we will authorize or provide the Service to you as quickly as your health condition requires, but no later than 30 days from receipt of your reconsideration request. If our decision is fully in your favor for a request for payment, we will pay for the Services no later than 60 days from receipt of your reconsideration request.

If The Center's decision is in your favor for a request for Service, we will do one of the following:

- Authorize those Services as quickly as your health condition requires, but no later than 72 hours from the date we receive notice of The Center's decision
- Provide those Services as quickly as your health condition requires, but no later than 14 days from the date we receive notice of The Center's decision

If The Center's decision is in your favor for a request for payment, we will pay for the Service within 30 days from receipt of The Center's decision.

Expedited (72-hour) Medicare Appeal Procedure

This procedure applies to denied requests for Services that you believe we should provide, arrange, or continue (does not apply to hospice care). This procedure does not apply to denied claims for payment. You may ask that we make an expedited decision on your reconsideration request. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 30 days for the standard Medicare appeal procedure decision. If it is in your best interest, we may extend the time frame to make our decision for an additional 14 days beyond the 72-hour

period. For example, you may need time to provide us with additional information, or we may need to have additional diagnostic tests completed. Also, our decision may take longer than 72 hours if we have to wait for medical information from a non–Plan Provider.

You must submit your reconsideration request within 60 days of the date on the denial notice. You or your physician may request an expedited Medicare reconsideration request by calling toll free 1-888-987-7247, or by writing to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Medicare Expedited Review. You may also fax your request to 1-888-987-2252, or deliver your request in person to your local Member Services Department. Specifically state that you want an expedited reconsideration decision, 72-hour reconsideration decision, or that you believe that your health could be seriously harmed by waiting 30 days for a decision.

If we deny your request for an expedited Medicare reconsideration request, we will automatically review your request under the standard Medicare appeal procedure. You do not need to submit a separate reconsideration request. If you disagree with our decision not to expedite your reconsideration request, you may file a grievance as described in the "Grievances" section. If our decision under the standard or expedited Medicare appeal procedure is not fully in your favor, we will automatically forward your request for reconsideration to the CMS contractor, The Center for Health Dispute Resolution (The Center), for an independent review. The Center will send you a letter with their decision within 72 hours of receipt of your case.

If our expedited decision is fully in your favor for the Services you requested, we will authorize or provide those Services to you as quickly as your health condition requires, but no later than 72 hours from receipt of your reconsideration request. If The Center's decision is in your favor for the Services you requested, we will authorize or provide those Services as quickly as your health condition requires, but no later than 72 hours from the date we receive notice of The Center's decision.

Support for Your Request

You are not required to submit additional information to support your request for Services or payment for Services already received. We are responsible for gathering all necessary information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your reconsideration request, information such as medical records or physician opinions in support of your reconsideration request. We will obtain medical records from Plan Providers on your behalf. If you have received Services from a non–Plan Provider, you will need to contact the non–Plan Provider to obtain your medical records. You may need to send or fax a written request. Ask your physician to send or fax the records directly to us, if possible. We will provide an opportunity for you to provide additional information in person or in writing.

You may submit any new evidence to support your reconsideration request of denied requests for Services by mail, fax, or phone (or in person) at the numbers or addresses listed above for expedited Medicare appeals and standard Medicare appeals.

If you decide to appeal or request reconsideration and want help, you may have a doctor, friend, lawyer, or someone else help you. There are several groups that can help you at the following toll-free numbers:

- Health Insurance Counseling and Advocacy Program at 1-800-434-0222 (*TTY 1-800-722-3140*)
- Medicare Rights Center at 1-888-HMO-9050
- State Ombudsman (for skilled nursing facility issues) at 1-800-231-4024
- Area Agency on Aging at 1-800-510-2020 (varies by county, check your phone book) or call Eldercare Locator at 1-800-677-1116

For information about who may file an appeal, please refer to "Who May File" below.

If You Disagree with The Center's Decision

If you disagree with The Center's decision about your standard or expedited reconsideration request, you may request a hearing before an administrative law judge by filing a written request at a Social Security office (or at a Railroad Retirement Board office if a Railroad Annuitant) or by writing to one of the following two locations:

- The Center for Health Dispute Resolution, 1 Fishers Rd., 2nd Floor, Pittsford, NY 14534-9597
- Kaiser Foundation Health Plan, Member Services, 393 E. Walnut St., Pasadena, CA 91188

This request must be filed within 60 days after the date of notice of The Center's adverse decision. This 60-day notice period may be extended for good cause by the administrative law judge. A hearing can be held only if the amount in controversy is $100 or more, as determined by the administrative law judge. An adverse decision by the administrative law judge may be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services, either by its own action or as the result of a request from you or from us. If the amount involved is $1,000 or more, either you or we may request that a decision made by the DAB be reviewed by a federal district court. The party requesting judicial review must notify the other parties involved. An initial, revised, or appeal determination made by us, The Center, an administrative law judge, or the DAB may be reopened (a) within 12 months, (b) within four years for just cause, or (c) at any time for clerical correction or in cases of fraud.

Immediate Quality Improvement Organization (QIO) Review

You may request an immediate Quality Improvement Organization (QIO) review if you believe you are being asked to leave the hospital too soon and we deny coverage of your continued stay in the hospital because hospitalization is no longer Medically Necessary. A QIO is a group of doctors paid by the federal government to review the medical necessity, appropriateness, and quality of hospital treatment furnished to you. When we inform you that you are being discharged, we will provide you a written "Notice of Discharge and Medicare Appeal Rights" that describes in detail the procedures available to you to request a QIO review.

When you are admitted to any hospital, you will be provided a document entitled "An Important Message to Medicare Beneficiaries." The document describes your rights while you are a hospital patient. Those rights include: (1) the right to receive all hospital care that is necessary for the proper diagnosis and treatment of your illness or injury and the right to have your discharge date determined solely by your medical need and not by any method of payment, (2) the right to be fully informed about decisions affecting the coverage and payment of your hospital stay and for any post-hospital Services, and (3) the right to request a review by a QIO if we determine that your hospital stay is no longer Medically Necessary and you disagree.

Requesting QIO review

When you receive the "Notice of Discharge and Medicare Appeal Rights," if you believe that you are being asked to leave the hospital too soon, you may request an immediate QIO review by phone or in writing. If you request a QIO review by noon of the first business day after you receive the "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of your hospitalization until the QIO makes a decision. By requesting QIO review, you may not use the standard Medicare appeal procedure or expedited Medicare appeal procedure described above. The QIO will respond to your request for review of the "Notice of Discharge and Medicare Appeal Rights" by phone or in writing. The QIO will ask you your views about your case before making a decision.

If the QIO agrees with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for all costs of hospitalization beginning at noon of the day after you receive the QIO decision. If you do not agree with the QIO decision, you may request that the QIO immediately reconsider your case. The QIO may take up to three business days from receipt of your appeal to make a decision. The QIO will inform you in writing of the reconsideration decision. If the QIO continues to agree with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for the cost of your continued hospitalization, beginning at noon of the day after you received the first QIO decision. If, upon reconsideration, the QIO disagrees with the "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of any additional hospital days approved by the QIO.

Note: If you do not request a QIO review, you will be financially responsible for the cost of your hospitalization beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights." You may use the standard Medicare appeal procedure or expedited Medicare appeal procedure described above if you do not request a QIO review. However, you may be financially responsible for the cost of your hospitalization, beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights," if the appeal decision is not in your favor.

Grievances

You can file a grievance for any issue that is not subject to a Medicare appeals procedure described above. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received. Grievances may be submitted orally or in writing and they must be submitted to a Member Service representative.

We will send you a confirming letter within five days of our receipt of your grievance. We will send you our written decision within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

Quality Improvement Organization Complaint Procedure

If you are concerned about the quality of care you have received, you may also file a complaint with the local Quality Improvement Organization, by writing to California Medical Review, Inc., One Sansome St., Suite 600, San Francisco, CA 94104-4448 (fax number 1-415-677-2185), or by calling toll free at 1-800-841-1602. Quality Improvement Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Quality Improvement Organization review process is designed to help stop any improper practices.

Who May File

The following persons may file a grievance, appeal, or reconsideration request:

- You may file for yourself. If you want someone to file for you, provide us in writing your name, your Medical Record Number, and a statement that appoints an individual as your authorized representative. An example of a statement is: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal or reconsideration request from Kaiser Permanente (or CMS) regarding Kaiser Permanente's [denial] [discontinuation] of Services." You must sign and date the statement. Your representative must also sign and date this statement unless he or she is an attorney. Include this signed statement with your appeal or reconsideration request. (Authorization forms are also available from any Member Services Department.)
- In most cases, you may file for your dependent child. In some cases, your child will have to appoint you as his or her authorized representative
- A non–Plan Provider may file a standard reconsideration request of a denied claim if he or she completes a waiver of liability statement that says he or she will not bill you regardless of the outcome of the reconsideration request
- A court-appointed guardian or an agent under a health care proxy to the extent provided under state law

Binding Arbitration

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc., (Health Plan), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
2. The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
3. The claim is *not* within the jurisdiction of the Small Claims Court

4. If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice
5. The claim is *not* subject to a Medicare appeals procedure

As referred to in this "Binding Arbitration" section,

1. "Member Parties" include:
   a. A Member,
   b. A Member's heir or personal representative, or
   c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.
2. "Kaiser Permanente Parties" include:
   a. Kaiser Foundation Health Plan, Inc. (Health Plan),
   b. Kaiser Foundation Hospitals (KFH),
   c. The Permanente Medical Group, Inc. (TPMG),
   d. Southern California Permanente Medical Group (SCPMG),
   e. The Permanente Federation, LLC,
   f. The Permanente Company, LLC,
   g. Any KFH, TPMG, or SCPMG physician,
   h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties, or
   i. Any employee or agent of any of the foregoing.
3. "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.
4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

For all claims subject to this "Binding Arbitration" section both Claimants and Respondents give up the right to a jury or court trial, and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Arbitration Advisory Committee and Independent Administrator

Health Plan appointed an Arbitration Advisory Committee to assist in the selection of an Independent Administrator to administer arbitrations under this "Binding Arbitration" section, and to provide consultation to the Independent Administrator in administering these arbitrations. Upon the recommendation of the Arbitration Advisory Committee, Health Plan selected an Independent Administrator to perform these administrative services.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Health Plan, KFH, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 East Walnut Street
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received.

All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, non-refundable, filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Independent Administrator waive the filing fee and the Neutral Arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Number of Arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the Neutral Arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one Neutral Arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two Party Arbitrators and a Neutral Arbitrator. The Neutral Arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one Neutral Arbitrator and two Party Arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a Party Arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a Single Neutral Arbitrator.

Payment of Arbitrator Fees and Expenses

Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the Neutral Arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select Party Arbitrators, Claimants shall be responsible for paying the fees and expenses of their Party Arbitrator and Respondents shall be responsible for paying the fees and expenses of their Party Arbitrator.

Costs

Except for the aforementioned fees and expenses of the Neutral Arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to Rules of Procedure developed by the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Advisory Committee. Copies of the Rules of Procedure may be obtained from the Member Service Call Center by calling toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, or (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the Neutral Arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section.

Termination of Membership

Your Group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 12:00 a.m. on the termination date (for example, if your termination date is January 1, 2003, your last moment of coverage was at 11:59 p.m. on December 31, 2002). In addition, a Dependent's membership ends at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates.

When your membership terminates under this section, Health Plan and Plan Providers have no further liability or responsibility under this *EOC*, except (1) as provided under "Coverage for Totally Disabled Persons" and "Payments after Termination" in this "Termination of Membership" section, and (2) if you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged.

This section describes how your membership may end and explains how you may be able to maintain Health Plan coverage without a break in coverage if your membership under this *EOC* ends.

Note: Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care and Out-of-Area Urgent Care and in the "Benefits" section about Out-of-Area dialysis care.

Termination Due to Loss of Eligibility

If you met the eligibility requirements listed under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer met those eligibility requirements, your membership terminates on the last day of that month at 11:59 p.m. unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Also, we will terminate your Senior Advantage membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months
- Permanently move from our Service Area
- Are no longer entitled to Medicare Parts A or B. Your Senior Advantage membership termination will be effective the first day of the month following the month when Medicare Parts A or B end. Note: If you were enrolled in Senior Advantage on December 31, 1998 and you did not have Medicare Part A, you will not be terminated simply because you continue to not be entitled to Medicare Part A through Social Security

Note: If you lose eligibility for Senior Advantage due to these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group's benefits administrator for information.

Termination of Group Agreement

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Coverage for totally disabled persons

If you became totally disabled after December 31, 1977, while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates, coverage for your disabling condition will continue until any one of the following events occur:

- 12 months have elapsed
- You are no longer disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC* including Copayments.

For Subscribers and adult Dependents, "totally disabled" means that, in the judgment of a Medical Group Physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "totally disabled" means that, in the judgment of a Medical Group Physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership at any time and return to the Original (non-Kaiser Permanente) Medicare fee-for-service program. However, before you request disenrollment, you should check with your Group's benefits administrator to determine if you are able to continue your Group membership.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the month following receipt of your written request, and no later than three months after receipt of your request.

If you request disenrollment at a time other than your Group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may disenroll by sending written notice to the address below. Also, you may disenroll at any Social Security office or Railroad Retirement Board office (if you are a Railroad Annuitant) by completing a written request for disenrollment. In addition, you may also call CMS at 1-800-MEDICARE (1-800-633-4227) (*TTY 1-877-486-*

2048). However, although optional, we request that if you disenroll at a Social Security office or Railroad Retirement Board office, you also notify us.

Kaiser Permanente Senior Advantage
California Service Center
P.O. Box 232407
San Diego, CA 92193-2407

Note: If you enroll in another Medicare+Choice plan, CMS will automatically terminate your Senior Advantage membership when your membership in the other organization becomes effective. In this case, do not send us a disenrollment request. If you disenroll and have Part B only, you will have to purchase Medicare Part A from the Social Security Administration to re-enroll in Senior Advantage in the future or to enroll in another Medicare+Choice plan.

Termination of Contract with CMS

If our contract with CMS to offer Senior Advantage terminates, your membership will terminate on the same date. We will advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- Your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility. Any such termination requires CMS approval
- You knowingly (1) misrepresent membership status, (2) present an invalid prescription or physician order, (3) misuse (or let someone else use) a Member ID card, or (4) commit any other type of fraud in connection with your membership (for example, you knowingly furnish us incorrect or incomplete information or you fail to notify us of changes that materially affect your eligibility or benefits)

Termination for Nonpayment

You are entitled to health care coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Termination of a Product or all Products

We may terminate a particular product or all products offered in a small or large group market as permitted by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to the Subscriber. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Group Agreement* upon 180 days prior written notice to the Subscriber.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Dues paid for the period after the termination date
- Pay you any amounts we have determined that we owe you for claims for Emergency Care and Out-of-Area Urgent Care or Out-of-Area dialysis care during your membership in accord with "Non-Plan Emergency Care or Out-of-Area Urgent Care and Out-of-Area Dialysis Care" in the "Requests for Payment or Services" section. Any amounts you owe us will be deducted from any payment we make to you

Review of Membership Termination

If you believe that we terminated your membership because of your ill health or your need for care, you may file a grievance as described in the "Dispute Resolution" section, or request a review of the termination by the California Department of Managed Health Care (please see "DMHC Complaints" in the "Dispute Resolution" section).

Continuation of Group Coverage under Federal or State Law

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to employees (and their covered family Dependents) of most employers with 20 or more employees. You must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group's benefits administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group.

If you choose not to apply for COBRA continuation coverage through your Group, you may be able to convert to a nongroup Plan as described in "Conversion of Group Membership to an Individual Plan" below. If you do enroll in COBRA, when you lose your COBRA eligibility, you may be able to continue coverage under state law as described in "State Continuation Coverage after COBRA coverage" below. Also, you may be able to convert to a nongroup Plan as described in "Conversion of Group Membership to an Individual Plan" below.

State Continuation Coverage after COBRA coverage

If you lose eligibility for COBRA coverage because you exhaust the length of time allowed for COBRA coverage, you may be eligible to continue your Group coverage under state law (State Continuation Coverage) if required by Section 1373.621 of the California Health and Safety Code. To continue your Group coverage under state law, you must call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, to request enrollment within 30 days before the date COBRA continuation coverage is scheduled to end and pay applicable dues to us. In addition, you must meet one of the following requirements:

- You are a Subscriber who was 60 years of age or older and were employed by your Group for at least five years before the date employment with your Group terminated
- You are the Spouse of a Subscriber who dies, divorces, legally separates, or becomes entitled to Medicare
- You are a former Spouse of a Subscriber

Termination of State Continuation Coverage. Coverage continues only upon payment of applicable monthly dues to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable
- The date you become entitled to Medicare
- Your 65th birthday
- Five years from the date your COBRA coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse
- When you fail to make payments to us when due

If you do not elect State Continuation Coverage, you may be able to convert to a nongroup Plan as described in "Conversion of Group Membership to an Individual Plan" below.

Conversion of Group Membership to an Individual Plan

If you no longer qualify as a Member described under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section, we will automatically convert your Group membership to our *Senior Advantage Individual Plan Agreement* if you still meet the eligibility requirements for Senior Advantage and have not disenrolled. If you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to a non-Medicare individual plan, if you apply within 31 days after your membership terminates. Your individual coverage begins when your Group coverage ends. You will have to pay Dues and the benefits may vary from this plan.

For information about converting your membership or about other individual plans, call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated Members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When your membership terminates, we will mail the certificate to the Subscriber unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the *Group Agreement* and this *EOC.*

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that made a part of your medical chart

For additional information about advance directives, including how to obtain forms and instructions, contact your local Member Services Department.

Agreement binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and the *Group Agreement*.

Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorneys' fees and expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Governing law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members not Health Plan's agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222 (*TTY 1-800-722-3140*), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Member rights and responsibilities

As a Member, it is important to know your rights and responsibilities, which are discussed in *Your Guidebook to Kaiser Permanente Services*. To obtain a current copy of *Your Guidebook*, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Named fiduciary

Under our *Agreement* with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this *EOC*. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*.

No waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, or physical or mental disability.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, and Social Security at 1-800-772-1213 as soon as possible to report the address change. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Overpayment recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member

Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week. You can also find the notice at your local Plan Facility or on our Web site at *www.kaiserpermanente.org*.

Definitions

The following terms, when capitalized and used in any part of this *EOC*, mean:

Charges: Either (1) for Services for which the provider was compensated on a capitation basis, the charges in the provider's schedule of charges for Services provided to the general public (or, for Members, the provider's schedule of charges for Services provided to Members, if different), (2) for items covered under "Drugs, supplies, and supplements" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item, or (3) for all other Services, the payments that Kaiser Permanente made for the Services.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

CMS: The Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) is the federal agency that administers the Medicare program.

Copayment: The amount that you must pay when you receive a covered Service as listed in the "Copayments" section. For certain Services, we will charge either the Copayment or 50 percent of Charges, whichever is less. For items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements," we will charge either the Copayment listed in the "Copayments" section or the amount we would charge a Member for the item if a Member's benefit plan did not cover the item, whichever is less.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible").

Dues: Periodic membership charges paid by Group.

Emergency Care: Emergency Care is Medically Necessary ambulance Services and evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility.

Emergency Medical Condition: An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - serious jeopardy to your health
  - serious impairment to your bodily functions
  - serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation.

Kaiser Permanente: Health Plan, Medical Group, and Kaiser Foundation Hospitals.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional organization.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Medicare+Choice organization and plan: A Medicare+Choice (M+C) organization is a public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with CMS and meets the M+C requirements. A Medicare+Choice plan is health care coverage offered by a Medicare+Choice organization that includes a specific set of benefits, Dues, and Copayments offered on the same basis to all Medicare beneficiaries residing in the service area of the M+C plan.

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Dues. This *EOC* sometimes refers to Member as "you" or "your."

Out-of-Area Urgent Care: An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non–Plan Provider for an unforeseen illness or injury if all of the following is true:

- You are temporarily outside of our Service Area
- The Services are necessary to prevent serious deterioration of your health
- Treatment cannot be delayed until you return to our Service Area

Plan: Kaiser Permanente.

Plan Facility: A Plan Medical Office or Plan Hospital. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of covered Services available from each Plan Facility.

Plan Hospital: Any hospital (including an Affiliated Hospital) in our Service Area where you receive hospital care pursuant to arrangements made by a Plan Physician. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of covered Services available from each Plan Hospital.

Plan Medical Office: Any outpatient treatment facility (including an Affiliated Medical Office) staffed by Plan Physicians. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of covered Services available from each Plan Medical Office.

Plan Pharmacy: Any pharmacy located at a Plan Facility or another pharmacy that we designate (including an Affiliated Pharmacy).

Plan Physician: Any licensed physician who is a partner or employee of Medical Group, or any licensed physician (including an Affiliated Physician) who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician, or other health care provider (including an Affiliated Provider) that contracts to provide Services to Members (but not including providers who contract only to provide referral Services).

Post-stabilization Care: Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-stabilization Care can be provided while you are still in a hospital Emergency Department, after you have been admitted to a hospital, or in another setting.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Northern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week.

Service Area: The following counties are entirely inside our Service Area: Orange and Los Angeles (except ZIP code 90704). Portions of the following counties, as indicated by the ZIP codes below, are also inside our Service Area: *Kern*: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518, 93531, 93536, 93560-61, 93581 *Riverside:* 91752, 92201-03*, 92210-11*, 92220, 92230*, 92234-36*, 92240-41*, 92253*, 92255*, 92258*, 92260-64*, 92270*, 92276*, 92282*, 92292*, 92320, 92324, 92373, 92399, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, 92877-83 *San Bernardino:* 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91766, 91784-86, 91798, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-94, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, 92427, 92880 *San Diego:* 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-09, 92013-14, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99 *Tulare:* 93238, 93261 *Ventura:* 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07*, 93009*, 93010-12, 93015-16, 93020-21, 93022*, 93030-36*, 93040, 93041-44*, 93060-61*, 93062-66, 93093-94, 93099.

*Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Please refer to "Your Primary Care Plan Physician" in the "How to Obtain Services" section for details.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed by the state of California and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care.

Spouse: Your legal husband or wife. For the purposes of this *EOC,* the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section).

Copayments

This section discusses Copayments only. It does not describe benefits. To learn what is covered for each benefit, please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, and Reductions" section, which applies to all benefits).

Copayments are due when you receive the Service, but for items ordered in advance, the Copayment will be the Copayment in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment. If we agree to bill you, we will increase the Copayment by $13.50 and mail you a bill for the entire amount.

Outpatient care	**Copayment**
Primary and specialty care visits (includes routine and urgent care appointments)	No charge
Well-child preventive care visits (23 months or younger)	No charge
Scheduled prenatal care and first postpartum visit	No charge
Outpatient surgery	No charge
Preventive health screenings (including colonoscopy and sigmoidoscopy)	No charge
Emergency Department and Out-of-Area Urgent Care visits	No charge
Manual manipulation of the spine to correct subluxation	No charge
Blood, blood products, and their administration	No charge

Hospital inpatient care	**Copayment**
Room and board and critical care units	No charge
Obstetrical care and delivery, including cesarean section	No charge
Physician, surgeon, and surgical Services	No charge
General and special nursing care	No charge
Anesthesia, prescribed drugs, and medical supplies	No charge
Blood, blood products, and their administration	No charge
Respiratory therapy	No charge

Ambulance Services	**Copayment**
Ambulance Services	No charge

Chemical dependency Services	**Copayment**
Inpatient detoxification	No charge
Outpatient individual therapy visits	No charge
Outpatient group therapy visits	No charge
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Dialysis care	**Copayment**
Inpatient care	No charge
Physician office visits	No charge
Dialysis treatment visits	No charge

Drugs, supplies, and supplements	**Copayment**
Items described in the "Benefits" section under the heading "Administered drugs, supplies, and supplements" and "Self-administered IV drugs, supplies, and supplements"	No charge
Diabetes urine-testing supplies	No charge up to a 100-day supply
Insulin-administration devices	No charge up to a 100-day supply

Drugs, supplies, and supplements	Copayment
Items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements" except that the items listed below have different Copayments	No charge up to a 100-day supply (or 3-cycles for oral contraceptives)
Amino acid-modified products used to treat congenital errors of amino acid metabolism and elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge up to a 30-day supply
Emergency contraceptive pills	No charge
Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are provided up to a maximum of 27 doses in any 100-day period)	50% of Charges* up to a 100-day supply
Drugs covered by Medicare	No charge

Limitation: The day supply dispensed at the Copayment may be reduced (a) to a 30-day supply in any 30-day period for specific drugs (please call our Member Service Call Center for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market.

Durable medical equipment	Copayment
Durable medical equipment	No charge

Family planning Services	Copayment
Covered family planning Services	No charge

Health education	Copayment
Individual office visits	No charge
All other covered Services	No charge

Hearing Services	Copayment
Hearing tests	No charge
Hearing aid(s) every 36 months	$500 allowance** per aid

Home health care	Copayment
Covered home health care, including physical, occupational, and speech therapy	No charge

Hospice care	Copayment
Covered hospice care for Members not entitled to Medicare Part A	No charge

Imaging, laboratory, and special procedures	Copayment
Imaging, laboratory, special procedures, annual mammograms, and ultraviolet light treatment visits	No charge

Infertility Services	Copayment
Covered Services related to the diagnosis and treatment of infertility	No charge
Inpatient laboratory, imaging, and special procedures	No charge

Mental health Services	Copayment
Inpatient psychiatric care and hospital alternative Services	No charge
Outpatient visits	No charge

Ostomy and urological supplies	Copayment
Ostomy and urological supplies	No charge

Physical, occupational, and speech therapy and multidisciplinary rehabilitation Services	Copayment
Physical, occupational, and speech therapy:	
Inpatient Services	No charge
Outpatient visits	No charge
Multidisciplinary rehabilitation Services:	
Inpatient	No charge
Outpatient	No charge

Prosthetic and orthotic devices	Copayment
Covered devices	No charge

Reconstructive surgery	Copayment
Inpatient care	No charge
Office visits	No charge
Outpatient surgery	No charge

Skilled nursing facility care	Copayment
Care in a Skilled Nursing Facility (up to 100 days per benefit period)	No charge

Transplant Services	Copayment
Inpatient care	No charge
Physician office visits	No charge

Vision Services	Copayment
Eye exams and glaucoma screening	No charge
Optical Services:	
Eyeglasses and contact lenses (including fitting and dispensing) every 24 months	$150 allowance**
Special contact lenses	No charge
Eyeglasses and contact lenses following cataract surgery as described in the "Benefits" section	$150 allowance**

* Charges means either (1) for Services for which the provider was compensated on a capitation basis, the charges in the provider's schedule of charges for Services provided to the general public (or, for Members, the provider's schedule of charges for Services provided to Members, if different), (2) for items covered under "Drugs, supplies, and supplements" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item, or (3) for all other Services, the payments that Kaiser Permanente made for the Services.

** Your price will be reduced by the allowance indicated. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

Annual Out-of-Pocket Maximum

There are limits to the total amount of Copayments you must pay in a calendar year for certain Services covered under this *EOC*. Those limits are:

- $1500 for one Member
- $3000 for the Subscriber and all his or her Dependents

Copayments for only the following covered Services apply toward these limits:

- Ambulance Services
- Home health care
- Hospital care, including Emergency Department visits
- Imaging, laboratory, and special procedures
- Physical, occupational, and speech therapy and multidisciplinary rehabilitation Services

- Professional Services

When you pay a Copayment for these Services, ask for and keep the receipt. When the receipts add up to the annual Copayment limit, please call our Member Service Call Center toll free at 1-800-443-0815 (*TTY 1-800-777-1370*), 7 a.m. to 7 p.m., seven days a week, to find out where to bring your receipts. When you bring them in, we will give you a document to show that you do not have to pay any more Copayments for the specified Services through the end of the calendar year.